‘Push on Through’: Children’s perspectives on the narratives of resilience in schools identified for intensive mental health promotion.

Ceri Brown* and Jeremy Dixon[b]

[*]Department of Education, University of Bath, Bath, U.K.; [b]Department of Social Policy Sciences, University of Bath, Bath, U.K.

*Ceri Brown is a Senior Lecturer in Education and Co-Director for Impact, with an interest in schooling and educational disadvantage, and education policy.

Jeremy Dixon is a Senior Lecturer in Social Work and Head of Group, with an interest in mental health policy and social work.

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Child mental health is a growing concern for policy-makers across the global north. Schools have become a key site for mental health interventions, with new programmes aimed at promoting ‘resilience’, through which children may maintain or regain mental health during adversity. As one of the first studies to explore the early impact of intensive mental health promotion in schools from children’s perspectives, we adopt a governmentality approach to consider the logic and techniques of such programmes with a specific focus on England. An innovative visual methodology was used to focus on student perspectives of mental health interventions in school. Young peoples’ photo representations of mental health were collected and used to stimulate focus group discussions with 65 students aged 12-14 across seven schools. ‘Resilience’ was seen to be the key organising concept for mental health interventions in schools. The concept was viewed as narrowly focussed on attitude towards,- and performance in,- school-work, with individuals being encouraged to ‘push-on-through’ difficulties to achieve success. Young people were critical of this approach suggesting several alternatives. These included increased access to independent mental health professionals, safe spaces within schools and mental health education that addressed the social and affective dimensions of mental health difficulties.

Keywords: mental health; resilience, children; schooling, photo-elicitation

The ‘mental health crisis’: a global concern

An ardent claim made by professionals and policymakers from across the global north, is that children are facing a mental health crisis, including in the United States, Australia and in Europe. Mental disorders have been attributed as the leading cause of disability for young people, with figures indicating that they affect 10-20% of children and adolescents worldwide (Kieling et al., 2011).

The identification and treatment of mental health problems has traditionally been the remit of psychiatry. Since the 1990s public health policies have broadened the scope of mental health interventions, with policies designed to promote good mental health and to increase the types of treatments on offer. Schools have become a key site for such initiatives, with both education and mental health professionals being tasked with educating pupils, identifying mental health problems and providing interventions (Adelman & Taylor, 2006). Increasingly, ‘resilience’ has become a central concept within such programmes, with most definitions viewing it as a form of positive adaption by the individual to maintain or regain mental health in the face of adversity (Herrman et al., 2011).

In this article we use a governmentality framework to critically analyse the way in which the concept of resilience has been applied within health services and schools. Govern*mentality* as defined by Foucault (1991) refers to a set of principles developed for managing populations across Europe in the post war period, with the objective to target and ameliorate behaviour through self-regulation. According to Rose (1989) this ‘new form of expertise’ (p.2) was prompted by governments’ impotence to control laws of the economy and population of the time, and their concession to devolve certain powers to professionals. A governmentality strategy sees the population as managed through the ‘apparatuses of security’, understood as the state institutions, designed to ‘ensure the optimal and proper functioning of the economic, vital and social processes’ (Dean, 2010, p.29). The seductiveness of this form of governance is, according to Rose

(1989) that is targets the 'soul'; not our actions per se. but the way we view them. This is founded in a discursive as opposed to a disciplinary power, where social action is coerced through professional knowledges and the displacement of authority from those who govern society, to those who serve it. The object of this form of governance is not the body but rather, individual 'subjectivity…[through] classifying and measuring the psyche… in diagnosing the causes of its troubles and prescribing the remedies' (p.2).

Different state and professional groups, such as policymakers or professionals in mental health or education, however, may have conflicting views on the way in which problems should be defined and governed. It is therefore important to consider, 'Who governs what? According to what logic? With what techniques? Towards what ends?' (Rose et al., 2006). In the following section, we set out the context for the development of mental health interventions in schools through charting public health strategies aimed at improving mental health. Following this, we review the strategies of countries at the vanguard of mental health education before focussing on England where this study is set. Here, we identify how notions of resilience have been defined in recent shifts in health and education policy. Schools and authorities are in the process of preparing for their new statutory responsibilities in mental health education. We focus on children in seven secondary schools identified by one local authority for intensive mental health promotion strategies.

A criticism levelled against governmentality theory is that it neglects individual agency, and views individuals as being easily shaped by experts (Taylor-Gooby & Zinn, 2006). In contrast to this, we aim to highlight children's perspectives on the dominant constructions of resilience within schools, which are then delineated from their own definitions of this concept. Here it is argued that children's scepticism of schools' resilience narratives cannot wholly buffer them from internalising these meanings. However, in this transitional period for mental health education, students' views are of critical importance to inform schools' policy direction.

Public mental health strategies and resilience

Public mental health strategies, can be seen to have been developed in Europe in the 1990s, gaining traction through The Melbourne Charter in 2008 (Wahlbeck, 2015). The WHO define mental health as,

> [A] state of well-being in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community (2001, p.1).

They argue that socio-economic and environmental factors play a significant role, with those in poverty facing greater mental health risks. Accordingly, the WHO has advocated that positive mental health should be promoted through public health policies; although these may not be directly health related (WHO, 2004). For example, education, housing or child-care policies might all improve mental health through minimising inequality and promoting health more generally. Central to this understanding is the view that structural factors of inequality are key determinants to mental health. However, while reducing inequality is seen to improve health outcomes, it has also been noted that most individuals who are exposed to economic or social stress do not go onto develop mental disorders (Friedli, 2009).

Resilience research has therefore sought to understand how certain individuals 'defy the odds', demonstrating 'positive outcomes' despite being subject to 'risk factors' such as poverty or trauma (Wexler et al., 2009). Sources of resilience are seen

to be multiple by researchers, with attention being focussed on personal, biological or environmental factors or the interactions between them (Herrman et al., 2009). Based on these understandings, policymakers are encouraged to increase protective factors and to provide interventions for those with a high risk of developing mental health problems. Schools are located as a key site for interventions, with the WHO encouraging education that 'equips children to flourish both economically and emotionally' through developing programmes involving teachers, pupils, parents and community (WHO, 2009, p.40).

When considering resilience from a governmentality perspective, it is therefore necessary to examine how concepts of resilience have been mobilised. In other words, the 'problem' of mental health may be construed very differently when viewed as an education, socio-economic, or health issue.

Many educational researchers have taken a critical view towards mental health education in schools. Specifically, mental health education has been seen to conflate the interests of the individual with those of economic competitiveness (see Reid 2009). From this perspective mental health education is seen to follow a rationalist assumption that the learner will be motivated to work hard on the assumption that good educational qualifications lead to good jobs. Accordingly, the 'problem' of mental health is seen primarily to represent an obstacle in the human capital- labour market pathway, where an individual's mental function must be (re)calibrated (Rose 1989) towards assuming the responsibility to engage in learning in school, in order to realise such ends (Lauder et al. 2009). Consequently, mental health education in schools has been seen as a particular narrative in the broader project of neoliberal schooling, in the construction of abject learners who do not achieve normative standards of educational success. It has been argued that the construction of mental health as an educational problem provides an understanding of educational (under) achievement as mental strength or weakness, which shifts the causal mechanisms away from the state and structural forces, and on to the individual learner (Brown and Carr 2018). From this perspective, the concept of resilience has been understood as pedagogical endeavour to instil the 'grit', 'determination' and hardened approach to coping with educational failure, in the unrelenting pursuit of exam results (Burman, 2018).

Having considered these debates, it is necessary to evaluate the 'logic', 'technique' and 'ends' (Rose et al., 2006) by which resilience is framed within national policies, and the respective roles given to education and health providers.

International approaches to mental health in education policy

Education policy within developed nations has reflected a shift from a 'pathological approach' to mental health issues, towards a 'salutogenic' one (Weare, 2010). While the former approach aimed to identify and correct mental health problems'- often decoded in terms of 'problem children' (Jull, 2008), - the latter reflects a universal whole-school approach, concerned with prescribing positive mental health for the total student body. While the US favours a top-down approach employing prescriptive training and formulaic manuals, Australia and England have adopted a 'bottom-up' approach in seeking to encourage user ownership and flexibility at the school/administrative authority level (Riekie et al., 2017). The concept of resilience has been central to policy advocated training resources. For example, the market leading PENN resilience programme (Positive Psychology Centre) in the United States, and the MindMatters

(2018) framework in Australia, both provide structures for schools purporting to build resilience.

In England, where this study is set, the approach towards child mental health is in a period of transition. The Government commissioned Children and Young People's Mental Health and Wellbeing Taskforce encouraged Government to improve access to specialist mental health services and to develop measures that would, 'place the emphasis on building resilience, promoting good mental health, prevention and early intervention' (DH, 2015, p.14). While the concept of resilience has been central to discussions about child mental health policies (PHE/DfE 2015,p.4; DfE 2016,p.4; DH/ DfE 2017, p.25) surprisingly, the term is not defined and there is only one reference to its indicative features, taken from one research study published over 30 years previously, which states;

> Resilience seems to involve several related elements. Firstly, a sense of self-esteem and confidence; secondly a belief in one's own self-efficacy and ability to deal with change and adaptation; and thirdly, a repertoire of social problem-solving approaches (DfE, 2016, p.8).

Government proposals envisaged that children with severe mental health needs would continue to be seen by specialist health services and that schools should assume a new position towards mental health in three ways. First, they should adopt a 'whole school approach' to mental health in which the responsibility for wellbeing is placed with teachers, pupils and family carers, with designated mental health leads acting as co-ordinators. Second, interventions for children with mild to moderate mental health problems should be delivered by new mental health support teams, (currently being piloted throughout 2019). Third, schools should have responsibility to educate students about mental wellbeing as part of the new curriculum subject 'Health education' to be statutory from September 2020 (DfE 2019). Definitions as to what constitutes a mild, moderate or severe mental health problem were not defined within policy (DH/DfE, 2017), although it was suggested that mood disorders, conduct disorders or substance disorders might constitute a mild to moderate disorder (p.38), whereas conditions requiring medication management might be viewed as severe (p.10). Consequently, thresholds of mental disorder are likely to be negotiated between health and education services.

Notably, the international policy narrative of mental health as a 'socioeconomic' issue is barely perceptible within current proposals, with structural disadvantages being limited to a deficit model focus upon problems of 'family conflict, truancy and worklessness' (DHSC/DfE 2018, p.16). This chimes with the Adverse Childhood Experiences (ACE) agenda, which across the UK is currently 'high on the political and public agenda' (DHSC 2018, p.1), and has been critiqued by educationalists for failing to 'take account of the social-cultural and political context which shapes the experience of communities, families and children' (Mowat & Macleod 2019, p. 7). To view social and health outcomes through an exclusive focus on familial behaviours and key events eclipses the impact of daily grinding adversity such as poor housing, financial insecurity and material deprivation, shown to be key stressors on school life for children in poverty (Brown, 2015). Given these new forms of mental health governance, there is a pressing need to consider how children view and interpret discourses about mental health and resilience, which we now address.

Research context and methodological approach

A two-part study was carried out in the South of England within one local authority pioneering a model of intensive mental health interventions, across 10 non-selective secondary schools (students aged 11-18), serving communities of socio-economic disadvantage. Interventions included; parenting courses for families, peer-mentoring, resources for pastoral support, and dedicated weekly contact hours with external therapists. We negotiated access into seven schools, to deliver presentations (typically within whole-cohort assemblies) to students in years' eight and nine (aged 12-14). In the first part of the study we asked students to send via a popular web/mobile application, images that represented their ideas about mental health concepts (e.g. resilience, wellbeing, mental health problems). For students without access to a mobile phone we provided a project email address. Once we confirmed that students were happy for us to do so, we anonymously uploaded the images to the social media platform, Instagram. To ensure non-identification, we informed students that we would use a software to obscure facial detail in any photo including a person. We only had to use this in one instance. In total we collected 36 images, which were printed for use as flash cards to stimulate discussion within guided focus-groups, several weeks after our initial presentations.

In the second part of the study, we conducted eight focus groups with children from seven schools, consisting of 65 children in total. Focus groups were between 3-10 students and lasted between 45-90 minutes. They were mixed sex and cross year group. We conducted one focus group in each school in all bar one school, which scheduled two focus groups to accommodate all the students who wished to participate. This method was chosen as it allowed for interaction between with children in which they could identify meanings and hierarchies in their own language, while also identifying differences between participants (Kitzinger, 1994). Data were collected between January and June in 2018. The inclusion criteria were that the child should be studying at the school in question and elect to participate, having received parental permission to take part (collected via the school). The designated mental health lead in each school gathered the names of interested pupils and arranged for them to attend within school hours. Prior to our first school visit we were advised that two participants identified as trans-gender and would prefer a mixed–sex grouping. We therefore decided to use this format in subsequent focus groups, but acknowledge a consequential possible inhibition to the discussion of gender, which did not emerge spontaneously in any focus group. A number of steps were taken to ensure that the focus groups were conducted ethically. Participants were asked to choose their own pseudonyms and were informed that focus group data would remain confidential unless they identified a potential risk of harm to themselves or others. We printed all images collected over the course of study in order to consider a broad cross-range of visual stimulus, and focus group participants were advised to neither identify any images they may have sent, or make a negative comment about any image provided. Both co-authors were facilitators for every focus group and at the start of each we were transparent about our interest in schools' new responsibilities to promote mental health, and our view of the looseness of current policy guidance and hence the importance in consulting students' perspectives on how mental health is to be understood. We signalled the broad range of images generated, in supporting our claim that no one perspective is any more or less valid. Participants were respectful of each other's views and no derisory comments were made. At the end of all focus groups, a brief debrief discussion took place. The key purpose was to ask participants whether any issues had caused any upset or distress and to identify potential

sources of support within the school, in the event that participants became distressed at a later date.

We were interested in children's experience of mental health 'concerns' according to schools' measure and therefore at the end of each focus group children were invited to complete a strengths and difficulties questionnaire (SDQ); the policy advocated measure by which schools are advised to form, 'a judgement about whether the pupil is likely to be suffering from a mental health problem' (DfE 2016, p.16). The imperative that students would not feel judged or labelled by their SDQ response informed our request to students not to include their real names, and our reassurance that their responses would not be correlated with their focus group contributions. Our invitation to complete the form always followed on from the focus group, so that those students who elected not to complete it would not feel deterred from contributing to the discussion. Fifty-seven children elected to fill-out the questionnaire, fifty-three of which were completed (see table 1). Responses from thirty-six students (or 63%) identified what would be classified as by the prescribed policy measure as a 'borderline' or 'abnormal' result, which would present as red-flags to elicit mental health support. The high proportion of students presenting a mental health concern for schools suggests that personal experiences may have underpinned some students' motivation to contribute to a discussion about mental health and schooling. Alternatively, students may have been influenced to identify mental health difficulties by the discussion and a different result may have been achieved had the questionnaire been completed before the focus group discussion took place. Demographic data from participants is reported in Table 1.

[Table 1. SDQ data by gender]

Within focus groups, students were sat around a table on which images collected from the first part of the study were placed. They were asked questions about how they defined good and bad mental health and were invited to choose pictures from the table to illustrate their ideas. Students were then asked how they defined the concepts central to educational mental health promotional policy, including 'resilience'(PHE 2015, DfE, 2016; DoH/DfE, 2017) and 'wellbeing' (DfE, 2016; PHE, 2015; DfE, 2019). They were also asked what they thought schools should teach children about mental health and how schools should support children with mental health issues.

Focus group data was recorded and transcribed by a professional transcription company. Data was analysed using a 'code and retrieve' approach to identify common phenomenon, collect examples of these and to identify themes and patterns within the data (Siedel & Kelle, 1995). Author 1 and author 2 coded transcripts from two focus groups independently. The authors then met to identify similarities and differences in coding and a coding frame was then agreed. This frame was then used by both authors and was regularly reviewed. No disagreements amongst authors emerged when coding subsequent transcripts. The initial coding phase generated codes labelled with close reference to participants' own words. Subsequent analyses aimed to reflect on and explain themes using a governmentality lens (e.g. to consider the causes and consequences of the dominant narrative of resilience that emerged).

Data and analysis of students' perspectives on mental health and schooling

Mental health problems and the experience of schooling

Mindful that school health policies are both mediated by and co-opt the broader discursive influences of 'public, popular and cultural spaces as pedagogical sites' (Rich, 2012, p.635) we acknowledge that children's' views of the nature of mental health problems were informed by several sources, including personal and family experiences, information from the media and mental health education in schools.

Research participants were asked within focus groups; 'What does mental health mean to you?' When describing mental health problems students often used their own terms rather than recognised diagnostic terms. The most common problem identified by participants was that of 'feeling trapped'. This was named by six of the focus groups, with participants in five groups selecting a picture of a person locked behind bars to illustrate this (see figure 1, photo 1).

[Figure 1. Students' representations of mental health problems]

Children identified mental health problems as something that affected the mind of the individual. Children picked a photo of brambles (figure 1, photo 2) to illustrate confusion and also used a drawing of a face being pointed to in order to illustrate a lack of confidence (figure 1, photo 3). For example, one participant stated, 'if your brain, like, or your confidence is really, really bad, like, you feel you can't trust anyone and everything. So you have to keep it to yourself, because you think that no-one will believe you or something' (Yellow, FG3). The experience of 'feeling trapped' was seen by participants to emanate from a lack of confidence and was beyond a matter of personal choice; voiced by one participant as, 'It's almost as if they want to get out but they just can't…' (Mango Chutney, FG 6).

Other mental health issues were raised by students in their own terms. A 'lack of trust' in others was identified as a mental health issue by four groups, although this problem category overlapped with 'feeling trapped' in two cases. 'Anger' was also identified as a potential mental health issue, with three groups identifying it as a problem in cases where the individual felt out of control or where it caused someone to lose friends. Other issues were identified as mental health problems by single groups and included, 'over-thinking situations', 'feeling unsafe', 'stress' and 'feeling stuck'.

When describing mental health problems children also drew on diagnostic labels. The most commonly used were 'anxiety' and 'depression', although other labels such as, 'Asperger's', 'attachment disorder' and 'substance misuse' were mentioned by single participants in passing. Anxiety was discussed in six of the focus groups, identified as a sense of fear or trepidation in five groups. Participants highlighted that the level of fear is disproportionate to the threat, with two students drawing on personal accounts of panic attacks e.g.; 'if you're like full of anxiety it's hard to speak out or even breathe' (Violet, FG6).

The problem of depression was defined by two of the groups in indicating that people with depression, 'don't care anymore' (Darren, FG7) or, 'don't get a lot of sleep at night' (Gafonda, FG5) and experienced feelings of sadness. One group noted how both anxiety and depression were related to 'self-harm'. Notably this group were critical of some children who self-harmed, claiming that, 'people are starting to like, self-harm, as like it is a trend' (Ebony, FG2) or because, 'they want some extra likes on social media' (Blue, FG2). In response to this point author 1 employed a reflective listening approach in acknowledging the frustration that some young people may feel when self-harming does not get the respect that it deserves. This led to a deeper discussion of the self-harm 'trend' as problematic for stigmatising those who self-harmed due to what was perceived to be genuine anxiety or depression.

Students within focus groups autonomously raised the connection between mental health and schooling, while differing in their views. In some cases, they identified school as the cause of mental health problems and pointed to the school environment or study expectations as a cause of negative emotions, such as stress and anxiety. For example, when talking about a writing initiative in primary schools, Rose recounted,

> I could never start a sentence and I would just feel everything. Like everything was a weight on my shoulders and I think that puts the pressure on so much, that it is just caving in…(Rose, FG6).

It was more common, however, for children to view mental health problems as something that might be aggravated rather than caused by schooling. For example, Harriet claimed that exams were often a cause of stress and worry amongst students, but identified that their response to these events, 'depends on their personality, how they look at the situation really' (FG6). Nonetheless, schools were seen as having an influence on the way in which a pupil experiencing a mental health problem might cope with these issues. Several participants argued that students' difficulty to access help was partly attributable to teachers' poor understanding of mental health issues and the impact on key health factors like sleep;

> Like some teachers don't like really know it's because they [children] have got a mental health problem, they just think that because of the stereotypical things, like we are all on our phones…or partying and I don't think that's really fair because people who genuinely suffer from it aren't getting help if they can't speak up (Gafonda, FG5).

This highlighted the costs of a 'salutogenic' mental health promotion model, where an emphasis on individual intervention may shadow the need for professional support.

School narratives of resilience

On being asked whether they had heard the term 'Resilience' it was evident that the focus-group participants overwhelmingly associated it with schooling. In asking children directly about their understanding of such policy concepts, we cannot be certain that they would have emerged autonomously, however the strong reaction 'resilience' provoked over other terms raised such as 'thriving' suggested that the term was familiar to many participants. Teachers, assemblies and lessons were initial connections made by students in five of the schools visited, and incited sighs, exclaims of exasperation and eye-rolling from children from two schools upon first mention of the word. Children reported that 'resilience' featured in the school motto of one school, in the exercise books of another, on the reception noticeboard and in the classroom walls of two further schools. One student even claimed it was 'one of the three Rs' the school used to 'try and apparently inspire you to do something' (Jeff,FG6). Resilience was perceived by students to not only be seen but also heard in school, as addressed to large pupil cohorts, most frequently in assemblies and lessons, particularly PSHE, but also in more formal academic subjects such as Maths and French. It was also a term they described as being mobilised by individual teachers, in castigating or deriding students considered lacking in it; for 'like [when] your behaviour isn't normal' (Jolene, FG8) or in one instance when a student was asked a maths problem that they didn't know, leading the teacher to say that the pupil, ' needed mental help' (Mr Spoon, FG6).

When then probed as to how they construed the school's understanding of resilience, there was a notable consistency in students' responses, indicating a construction narrowly orientated towards children's attitude to, and performance in,

school-work, particularly in relation to tests and examinations. The predominant descriptor used was resilience as a 'mindset' or the exclusive product of individual effort; 'if you are doing a test and you are struggling like, just carry on trying' (Meg ,FG5) regardless of the consequences, 'keep going no matter what happens' (F/M, FG7).

We termed schools' construction of resilience as, 'push-on-through', in lieu of its expression using such words, -or a proximal equivalent, -that emerged in seven of the eight focus groups and across each of the schools visited, e.g.;

> They said in the school quite a lot recently, like, try to be resilient. Like, even if you're struggling with, like, work or anything then you have to try and be positive and, like, get through it. (Chillies, FG1)

> So I think they use it a bit if you get knocked down it's about getting back up again, so if something's happened to you…you need to keep working so that you can get back to where you were and then you have the ability to push through and be even better. (Purple, FG2)

One or two young people acknowledged that the school's definition of resilience held some merit, in generating a sense of agency to affect their futures, but nevertheless that there were limits to individual effort;

> I mean when you hear it [resilience] you say, "Yes, that's right." I mean you've got to keep going, keep at it, be tenacious...It will get you far. I mean I think it's a kind of good thing to think about, but then when you're in that situation, mental health for instance, and then you're just kind of thinking, "Stay resilient. Stay resilient." But then you just, occasionally it's your will…it's been so difficult because sometimes when people say "Be resilient." It's just basically saying "But I can't", it's like irony because it doesn't work. (Mr Spoon, FG6)

Other students were more emphatic that the 'push-on-through' response 'chipped away at' (Mango Chutney, FG6) or 'battered down' (James Bond, FG4) their motivation to be in school, and affected confidence in their academic performance;

> If you think about it, if you fail a test and even if they say "Come back", "You're going to work harder" ,"You can get it" that really knocks you down because you're a bit like, "I did revise for that"…and it's difficult to then come back and just be expected to just come straight back from that. (Blue, FG2)

> It kind of gives you anxiety and sometimes stress from the amount that they're putting on you, so it's like for your exams they like tell you to revise and keep revising and then if you fail then they just tell you to kind of get back up and work more and revise more (Purple, FG2).

Students were particularly sceptical about the application of a 'push-on-through' rhetoric to the issue of mental health;

> So never give up, always push through and it's like it's easier said than done because…say for example you broke your ankle…right in a performance, and then your teacher says the next day…"You'll be fine. Push through it. You can do it." But it's not that simple with mental health, it's, you can't just fix it, you can't give

> yourself an operation on the ankle, because it just won't get fixed (James Bond, FG4)

In voicing a critical appraisal of the schooling narrative of resilience as 'repetitive' and 'meaningless', students decried it for perpetuating a sense of 'false hope' that was unsubstantiated; 'To be honest it sounds like they're just saying it to say it, they got to put something out there, but it's not working' (Gus FG4). In recognising the performative pressure behind resilience narratives, some students attributed the school as responsible, 'they just kind of want you to do well in the tests so they can push you off onto the school statistics', (Stella, FG7). Other students saw the school as impotent to higher powers,

> I don't think it's directly teachers; I think it's just the [education] system in general…all the system wants is for you to get good grades. The system doesn't care. I mean, the teachers do, but when it's set up around not caring then there are going to be problems in it. (Darren, FG7)

Students' accounts indicated the inculcation of an education policy discourse of mental health as an 'educational problem' through a narrative of resilience, framed as children's orientation to learning and achievement. This complements other qualitative research with young people receiving therapeutic treatment, who understood their own mental health in terms of mental strength or weakness, and their ability to control their mind and face life's problems (Ungar & Teram, 2000). Governmentality has been critiqued as an approach for its 'underdeveloped account of agency' where people are seen as 'inherently manipulable' (Taylor-Gooby & Zinn, p.407). Students' critical appraisals of a push-on-through narrative do counter such a charge. However, the sense of inadequacy that arose for young people in failing to achieve a state of resilience defined in these terms, highlights that learner orientations can still be impacted in the absence of a total ideological alignment with policy directives.

Alternative constructions of resilience

Not one student in our sample claimed to have achieved a stable sense of resilience as defined through the schools' push-on-through logic. Reflecting their construction as 'abject' learners (Popkewitz, 2012, p.185) almost two thirds of children were identifiable by the policy measure as being 'abnormal' or 'borderline' in their mental health status. Bragg (2007) has argued for a governmentality framework in analysing learner identities that are promoted in school through the, 'questions of whom and what is problematized or rendered 'abnormal' in the process' (p.345). In the shadow of the normative ideal is the possibility to reconstruct oneself through the 'productive aspects of power' where learners are required to 'constitute themselves as autonomous, responsible and choosing subjects' (Bragg, 2007, p.346). This was also evident in our sample in that students did not submit to their failure to be resilient in the school's terms. In contrast, our participants' responses indicated a number of alternate constructions to the 'push-on-through' narrative. For some children the concept was perceived as a strategy to actively avoid seeking mental health support. Six children connected with images portraying resilience as a fort or a balloon (see figure 2.) in indicating feeling, 'down, but...not showing it' (Bob FG5). They described resilience as a 'mask' or 'wall' because, 'a lot of people do hide who they really are because they're scared that others will hurt them' (Lee, FG4). The trade-off however, was

unsustainable, in generating an emotional response that, '[you] are about to explode inside' (Bob, FG5).

[Figure 2. Students' representations of resilience as avoiding seeking support]

The majority of participants, however, held more positive associations, in selecting images portraying; light-in-darkness, friendship, and the emergency services (see figure 3). Themes drawn from student's responses included; 'hope', 'trust', 'faith' and 'balance'. Fundamentally, it was acknowledged that the source of resilience was not solely attributable to individual effort, but involved the giving and receiving of help from others. These understandings of resilience chimed with an ecological perspective, as advocated by Howard et al. (1999), in emphasising the social constituents of familial, peer and community support. Children's own understandings of resilience, could be seen to push back against policy narratives decoded through schooling, in reclaiming the social world, - albeit a 'shrunken' version of it (Henderson & Denny 2015, p.8),- from more individualistic policy constructions;

> Because being resilient, you don't just have to push through by yourself. You can trust someone, you can be with someone (Sky, FG3).

Figure 3. Students' representations of resilience as seeking and giving support

Towards a mental health strategy for schools: an alternative to push-on-through

Discussion of the various ways in which mental health was understood by students (vis-à-vis schools) invited reflection as to how schools could improve upon their mental health strategy. Children's responses indicated three discrete approaches; critiques of current provision, support for mental health problems and an ideal model for mental health education.

Critiques of current provision

A deeply troubling finding arising from students' review of current provision was that of the perceived inadequacy of current schooling strategies to tackle bullying. When asked specifically about the school's mental health strategy, children in five of the eight focus groups raised the issue of bullying as central to the effectiveness of a school's approach. Bullying was seen to both exacerbate existing mental health problems for children, as well as to trigger lower-level issues such as anxiety and depression. Challenges included; a denial of the problem by school leaders; a disjointed and opaque referral system; the requirement for, and the difficulty in sourcing, evidence; the conflation of social exclusion with bullying; and lack of follow-up with victims. Current approaches were perceived to avoid, as opposed to resolve, the issue, and invariably concerned separating the victim from the perpetrator. Other participants however, complained that schools' conflation of mental health problems with bullying was reductive, as relayed through mental health education in schools, 'Other people within our school do suffer with other mental health problems rather than just getting bullied' (unidentified, FG2).

Other issues concerned teachers' failure to address suspected mental health concerns 'because they might feel like it's not their place to go to'(Gafonda, FG5) or the misdirection of mental health concerns onto learning or behavioural support services. Some students attributed this to inadequate mental health literacy,

> I think most teachers think … mental health problems are showing as you being sad or isolated or not particularly into anything, whereas it can be the opposite…but teachers don't realise that and just approach it in the form of punishments for bad behaviour (Darren, FG7).

These accounts indicate a paradox in that while mental health is deciphered in policy terms as problematic primarily in terms of the impact of children's behaviour on learning (see DfE 2016), children understood anti-social behaviour as both a *trigger for* as well as a *consequence of* mental health problems.

Support for mental health problems

A number of students advocated the opportunity to speak with professionals (therapists) in school as it was thought to be 'easier' (Lee, FG4) to speak to a 'stranger', as well as the confidence that 'whatever they say will be confidential'(Ash,FG4). While other students in schools lamented the lack of signposting for current availability.

A recurrent suggestion raised across six schools was that of a 'safe space' defined as;

> An environment that you can go to where there are people who trust,- or maybe nobody at all,- where you can just, like, feel everything you want to feel, say everything you want to say, and no one's going to really judge you for it (Red,FG1).

Three of the schools offered a dedicated open-access room, which were deeply valued by students in order to process feelings or simply to 'get out of the class' (Violet,FG6) when feeling overwhelmed. A 'safe space' was recognised for the opportunity it afforded to be alone;

> Somewhere where you can always go, but no-one else is going to be there and it creates a sensation of relaxation like comfort for you. It's your space (Meg,FG5).

While at other times students sought sanctuary among others;

> I think a safe space can be a space where you can be you [and] you have this group of people that you know and sometimes don't even know…like, an anonymous group, where you can…kind of just explore your own emotions further… Just with other people (Violet, FG1).

An ideal model for mental health education

A number of students voiced frustration about current didactic approaches to mental health education, delivered through assemblies or stand-alone PSHE lessons;

> So, I think if they integrated it with a different type of lesson…maybe like English, they do like debates a lot in some of our English lessons, so [then]…you'd get people actually talking, it would be a lot more integrating and effective than if you did it in a trademark PSHE lesson. (Sky,FG3)

It was felt that an ideal education strategy should give a voice to students' own views and experiences in, 'actually taking into consideration what the young people who have these issues have to say' (Red,FG1). Some students pointed to the focus group itself as an opportunity to engage with and deconstruct the meaning of mental health as an

effective health promotion intervention, 'I would say … sessions with the actual person like this where we can think about what it [mental health] actually really means' (Max,FG2)

Participants believed that mental health literacy should extend beyond the most common conditions (such as anxiety and depression) to include 'the ones that people don't recognise, that people don't really know about'(Ash, FG4). While a handful of students voiced the importance of guidance in spotting 'some of the signs' (Violet,FG1) of mental health problems, there was also a strong sense that it should address the social, emotional and practical aspects of poor mental health; 'how much it actually affects your life…and how it can make a person feel' (Ebony,FG2).

The resounding issue raised by participants across six of the seven schools, was the need to provide tangible solutions and advice to 'help other people with it' (Stella, FG7). For example, through having the testimonials of mental health survivors, especially older peers who would 'know where you're coming from' (Mango-Chutney, FG6).

Indeed, the importance of a mental health education strategy that goes beyond literacy was highlighted by one student, in recognising that information out of context can exacerbate the stigmatisation of mental health problems;

> Personally, I don't think that they [teachers] should tell people [students] in as much detail, because there are some people out there who just make a joke of it [mental health problems], make fun of you for it because they will know what it is and they would know that you have it (Max, FG2).

Conclusion: Reclaiming resilience in schools as a route to children's mental health

In this paper we have applied a governmentality critique to consider how resilience-enhancing interventions are formed at national levels with a specific focus on how these policies are experienced by children in England. The joint ministerial approach tasking mental health responsibility to schools in England is broaching unchartered territory, with current proposals posing challenges both to schools and mental health providers. Under new proposals, the role of schooling is decentred through a prevention approach that calls upon a range of services targeting early intervention at children with mental health problems deemed to be 'high risk'. However, schools have an increased role with respects to the normative student population following the pledge that 'every child will learn about 'mental wellbeing' in school (DH/DfE, 2017; DfE, 2019). This is arguably the consequence of competing and alternative constructions of the core problems underpinning policy narratives; the 'education' problem seeking to calibrate optimal learning orientations and the 'health' problem seeking to plug the treatment gaps under existing provisions (PHE, 2015). By contrast, the international policy narrative of mental health as a 'socioeconomic' issue is simply ghosted (Allan & Youdell, 2017) in the notable absence of factors such as health inequalities, poor living conditions and financial pressure on families.

While mental health is defined as both an educational and health problem at a policy level, our research identifies that children strive to define mental health on their own terms. Furthermore, they were able to adopt a critical stance towards the concepts of mental health taught within schools. Nevertheless, children's agency to define mental health issues were seen to be mediated by the mental health policies adopted by schools. As Dean (2010) observes, while a freedom is invoked through a governmentality logic

in that social actors are required to think and act; 'thinking is a collective activity. It is a matter not of the representations of individual mind or consciousness, but of the bodies of knowledge, belief and opinion in which we are immersed' (p.24). Children's efforts to critique such policies were, therefore, shadowed by the prevailing narrative of mental health (problems) within their schools and the causes and solutions they pointed to.

Central to the mental health promotion strategies canvassed by schools, was the concept of 'resilience' as the key driver. These findings support observations by commentators that resilience narratives have become dominant within mental health education in schools. It was also notable how narratives of resilience were understood by children. It has been argued that resilience narratives within UK policy have shifted away from a focus on contexts and environment, towards a focus on individuals and families (Burman, 2018). Children in our study were critical of how resilience was taught, seeing it as performative measure. In line with concerns raised by critical commentators (Burman, 2018; Brown & Carr, 2018), the 'push-on-through' narrative of 'resilience' was perceived as reflecting an individual attitude towards learning and academic achievement, with little focus on the wider environment. While this was experienced as partially empowering by a few, the majority felt it lowered their motivation to study; being used by adults to castigate or blame individuals for experiencing difficulties. Furthermore, the narrative was seen to discourage those with mental health problems from seeking help within school, highlighting that the 'prevention and early intervention' logic to mental health (DH, 2015, p.14) envisaged by the Department of Health was not deciphered by schooling policies. The implications of such findings highlight that the role of schools, families and communities in strengthening children's resilience were not seen by the students in our research to be foregrounded in schools' framing of mental health. It is arguably a 'cruel' optimism (Berlant, 2011 in Denny & Henderson, 2015,p.8) however, in over inflating the agentic power of individuals to buffer structural and systemic causes of social injustice, justified in terms of what is feasible to change.

It was notable that children in our research focussed on specific social sites within their own accounts. Indeed peer, familial and community relationships were the only support mechanisms signalled by children in their 'alternate' conceptions of resilience. These social structures were recognised by children as being the causal mechanisms for poor mental health; e.g. exam stress, the performative culture of schooling, and the omnipotent forms bullying brought about through social media. Nonetheless, children recognised that teachers were constrained by wider structural forces, such as education policy. While students perceived teachers to not see it to be their job to address mental health, this did not reflect (in the main) a belief that teachers were apathetic to children's wellbeing, but rather, children's recognition of the current limitations to teachers' mental health literacy, and the performative pressures they also faced.

It has been argued that the framing of resilience as an object of schooling reflects a form of individual acquiesce, as opposed to resistance, (Burman 2018,p.24) in undermining the protest and political debate necessary to incite collective action to challenge the state apparatus that contribute to the very problems it purports to address. We fear that the neglect of structural in place of agentic mechanisms for change will inevitably dampen appetite to address the former, or worse still (noting an emergent discourse within the psychological sciences) to the message received by children in this study that, 'resilience is evidenced *because* of the challenging environment, not *in spite* of it' (Hooper, 2009,p.19 our emphasis) as leverage to justify a continued austerity approach to public policymaking.

Policy critics have questioned the utility of a resilience narrative as a developmental aim for children (O'Brien, 2014; Henderson & Denny, 2015; Burman, 2018). While findings from this study may support such caution, nevertheless the potential indicated in the alternative constructions raised in this study give sway to the possibility to reconstruct the key definitional terms underpinning school mental health promotion strategies. The definitions of resilience that students raised as more centrally constitutive of their own values included; 'hope', 'trust', 'faith' and 'balance'. Themes that were intimately connected to the role of valued others including friends, (some) family, (some) teachers, and trusted adults, and also raised the perspective of one route to resilience as through the helping and supporting of others.

In terms of school-based support, findings highlighted the value that children attributed to opportunities to speak with professionals who were not accountable to the academic performance of schools, which offers some optimism to the introduction of mental health support teams funded by CCGs (DHSC/DfE,2018,p.26) currently underway in target pilot areas of England. Findings also highlighted the potential for 'space spaces' to be created within the school environment, for children to seek both solace and support from external pressures.

Findings also signalled children's views on the key foundations for an ideal mental health strategy in school. This included; more provision for child informed discussion as to the affective and well as social dimensions to mental health problems and a platform for student-led debate and ownership for the ways in which good mental health is defined and promoted in school.

The current looseness of key definitional terms underpinning the policy aspiration towards mental health promotion in schools in England may be well intentioned to avoid a prescriptive and mechanistic approach to mental health education, and in being responsive to local context. But the results from this study suggest that schools may risk inadvertently relaying the message to students that good mental health is primarily a product of individual effort and synonymous with consistent (relentless) effort towards academic performance. The consequence of over-inflating the agency with which children can address the mental distress they experience at school is that students with mental health issues may actually be discouraged from seeking support.

The policy implications of this study call for grassroots stakeholder informed definitions of good mental health, which may lead to the development of mental health concepts more centrally constitutive of good mental health as defined by teachers, school leaders, school-based therapists, parents, and fundamentally, young people themselves.

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Data Availability Statement

The visual data that support the findings of this study are openly available in Instagram at https://www.instagram.com/youngpeoplesmentalhealthstudy/. A summary of the focus group data that support the findings from this study are available from the corresponding author upon reasonable request.

Ethical Guidelines

This study adhered to the BERA Guidelines for Educational Research, fourth edition (2018). The ethical considerations were prepared and agreed by both authors and were approved by the University institutional ethics committee as a condition of funding.

Conflict of Interest

No conflict of interest is reported.

References

Adelman, H.S. & Taylor, L. (2006). Mental health in schools and public health. *Public Health Reports*, 121(3), 294-298.

Allan, J., & Youdell, D. (2017). "Ghostings, Materialisations and Flows in Britain's Special Educational Needs and Disability Assemblage." *Discourse: Studies in the Cultural Politics of Education* 38(1),70–82.

Bragg, S. (2007) "Student Voice" and Governmentality: The production of enterprising subjects? *Discourse: Studies in the Cultural Politics of Education,*28(3)343-358.

Brown, C. (2015) Educational Binds of Poverty: The Lives of School Children, Abingdon:Routledge

Brown, C. & Carr, S. (2018). 'Education policy and mental weakness: a response to a mental health crisis' *Journal of Education Policy,*

Burman, E. (2018). '(Re)sourcing the Character and Resilience Manifesto: Suppressions and slippages of (re)presentation and selective affectivities', *Sociological Research Online* 23(2),416 –437.

Dean, M., (2010). Governmentality: Power and rule in modern society. 2nd Edition. London:Sage.

DH/DfE. 2017. *Transforming Children and Young People's Mental Health Provision: a Green Paper:* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664855/Transforming_children_and_young_people_s_mental_health_provision.pdf

DHSC/DfE (2018). *Government Response to the Transforming Children and YoungPeople's Mental Health Provision: A Green Paper* https://www.gov.uk/government/publications/response-to-the-select-committee-report-on-the-children-and-young-peoples-mental-health-green-paper

DHSC (2018) Routine enquiry about adverse childhood experiences: implementation pack evaluation: https://www.gov.uk/government/publications/routine-enquiry-about-adverse-childhood-experiences-implementation-pack-evaluation

DfE (Department for Education). (2016).*Mental Health and Behaviour in Schools: Departmental Advice for School Staff*. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/508847/Mental_Health_and_Behaviour_-_advice_for_Schools_160316.pdf.

DfE (Department for Education). (2019)All pupils will be taught about mental and physical wellbeing. Press release: https://www.gov.uk/government/news/all-pupils-will-be-taught-about-mental-and-physical-wellbeing.

DH (Department of Health). 2015. *Future in Mind* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

Foucault, M. (1991). 'Governmentality'. In, G. Burchell, C. Gordon, & P. Miller, Eds. *The Foucault Effect: Studies in Governmentality*. Chicago:Chicago University Press,87–104.
Friedli, L., (2009).*Mental health resilience and inequalities.* Copenhagen: World Health Organisation Europe.
Henderson, J & Denny, K. (2015).The resilient child, human development and the "postdemocracy"*BioSocieties*,1-27.
Hooper, L. M. 2009. 'Individual and Family Resilience: Definitions, Research, and Frameworks Relevant for All Counselors' The Alabama Counseling Association Journal, 35 (1) 19-26
Howard, S., Dryden, J., & Johnson, B. (1999). Childhood Resilience: Review and Critique of Literature.' *Oxford Review of Education* 25(3): 307–323
Jull, S. K. (2008). 'Emotional and Behavioural Difficulties (EBD): the Special Educational Need Justifying Exclusion. *Journal of Research in Special Educational Needs* 8:13–18.
Kieling, C., Baker-Henningham, H., Belfer, M., Conti, G., Ertem, I., Omigbodun, O., Rohde, L.A., Srinath, S., Ulkuer, N. & Rahman, A., (2011). Child and adolescent mental health worldwide: evidence for action. *The Lancet*, *378*(9801)1515-1525.
Kitzinger, J., (1994). The methodology of focus groups: the importance of interaction between research participants. *Sociology of health & illness*, 16(1)103-121.
Lauder, H. (2009). 'Policy and Governance, Introduction' in Knowledge, Values and educational policy: A critical perspective, by H. Daniels, H. Lauder and J. Porter, (eds) London:Routledge.
MindMatters, (2018). *What is MindMatters?* Accessed at: https://www.mindmatters.edu.au/about-mindmatters/what-is-mindmatters
Mowat, J & MacLeod, G. 2019, *Poverty, attainment and wellbeing: Making a difference to the lives of children and young people*. Scottish Universities Insight Institute.
O'Brien S (2014) Graceful Failure: The Privatization of Resilience. Review of Education, Pedagogy, and Cultural Studies 36(4):260-273.
(PHE) Public Health England. (2015). *Promoting Children and Young People's Emotional Health and Wellbeing:* https://www.gov.uk/government/publications/promoting-children-and-young-peoples-emotional-health-and-wellbeing.
Public Health England / Children & Young People's Mental Health Coalition, (2015). *Promoting children and young people's mental health and wellbeing. A whole school and college approach*. London:Public Health England.
Popkewitz, T. 2012. "Numbers in Grids of Intelligibility: Making Sense of How Educational Truth is Told." In H. Lauder, M. Young, H. Daniels, M. Balarin, and J. Lowe. *Educating for the Knowledge Economy: Critical Perspectives*, 169–191. London: Routledge.
Positive Psychology Centre, (2018). Resilience Skill Set. Online at: https://ppc.sas.upenn.edu/resilience-programs/resilience-skill-set.
Reid, A. (2009). Revolution or reversion? A review of two key aspects of the Rudd government's
"education revolution". Journal of the Home Economic Institute of Australia, 16(3), 2–8.
Rich, E. (2012) Beyond School Boundaries, *Discourse: Studies in the Cultural Politics of Education* 33(5)635-654.

Rose, N. (1989). *Governing the Soul:The Shaping of the Private Self*, London:Routledge.
Rose, N., O'Malley, P. & Valverde, M., (2006). Governmentality. *Annu. Rev. Law Soc. Sci.*, 2,83-104.
Seidel, J., & Kelle, U. (1995). Different functions of coding in the analysis of textual data. In U. Kelle (Ed.), Computer-dided qualitative data analysis: Theory, methods, and practice. Thousand Oaks, CA: Sage
Taylor-Gooby, P. & Zinn, J.O., (2006). Current directions in risk research: new developments in psychology and sociology. *Risk Analysis: An International Journal,* 26 (2),397–411.
Ungar, M. & Teram, E. 2000. 'Drifting Toward Mental Health: High-Risk Adolescents and the process of Empowerment' Youth and Society 32(2) 228-252
Wahlbeck, K., (2015). Public mental health: the time is ripe for translation of evidence into practice. *World Psychiatry*, *14*(1), 36-42.
Weare, K. (2010) Mental Health and social and emotional learning: evidence, principles, tensions, balances. *Advances in School Mental Health Promotion*, ,5–17.
Wexler, L.M., DiFluvio, G. & Burke, T. K. 2009. 'Resilience and marginalized youth: Making a case for personal and collective meaning-making as part of resilience research in public health' Social Science & Medicine69 (4) 565-570
WHO (2001). Strengthening mental health promotion. Geneva, World Health Organization (Fact sheet, No. 220).
WHO. (2014). Global school health initiative. Geneva: World Health Organization. http://www.who.int/school_youth_health/gshi/en/
WHO, (2005). *Promoting mental health: summary report*. A Report of the World Health Organization, Department of Mental Health and Substance Abuse, Geneva: World Health Organization.
WHO, (2004). *Prevention of mental disorders: effective interventions and policy options. Summary Report.* A Report of the World Health Organization, Department of Mental Health and Substance. Geneva: World Health Organization.
WHO (2009) Mental Health, Resilience and Inequalities, World Health Organization, Europe. http://www.euro.who.int/__data/assets/pdf_file/0012/100821/E92227.pdf